

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001174		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - METRO SPECIALTY SURGERY CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2015	
NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 JEFFERSONVILLE, IN 47130			
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification survey was conducted by the Indiana State Department of Health in accordance with Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 07/30/15</p> <p>Facility Number: 012244 Provider Number: 15C0001174 AIM Number: None</p> <p>At this Life Safety Code Recertification survey, Metro Specialty Surgery Center LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors.</p>			K 000			
K 029	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems. 38.3.2, 39.3.2</p>			K 029			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 2 hazardous areas, such as a general storage rooms, were provided with a self closing devices which would cause the doors to automatically close and latch into the door frames. LSC 38.3.2.1 refers to LSC 8.4. LSC 8.4.1.3 requires doors in barriers to have a 3/4 hour fire resistance rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. This deficient practice could affect any patients in the facility. Findings include: Based on observations on 07/30/15 during a tour of the facility from 12:10 p.m. to 2:15 p.m. with the business manager, the surgery general storage room, which measured three hundred eighty two square feet and stored sixteen shelves of combustible cardboard boxes of surgery scrubs, plastic surgery supplies, and paper, and the operating room general storage room, which measured one hundred twenty eight square feet and stored thirty five shelves of combustible cardboard boxes of plastic surgery supplies and paper products, each lacked self closing devices on the room door. This was verified by the business manager at the time of observations and acknowledged by the administrator at the exit conference on 07/30/15 at 2:25 p.m.	K 029			
K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050			

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K 050	Continued From page 2 20.7.1.2, 21.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct quarterly fire drills on 1 of 3 shifts for 2 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including patients, staff, and visitors. Findings include: Based on review of Fire Drill Records with the administrator on 07/30/15 at 12:20 p.m., there was no fire drill documentation for the first shift, third quarter and fourth quarter of the year 2014. Additionally, based on interview with the administrator during the review of the Fire Drill Records, there was no other documentation available for review to verify these drills were conducted. This was verified by the administrator at the time of record review and acknowledged by the administrator at the exit conference on 07/30/15 at 2:25 p.m.	K 050			
K 051	416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1, 21.3.4.1 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure 20 photoelectric smoke detectors, 4 audible/visual devices, 1 fire alarm	K 051			

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K 051	<p>Continued From page 3</p> <p>panel, and 4 manual pull station boxes, which were all fire alarm system components were functional tested annually and the results of such testing listed clearly on inspection reports to identify all devices had been tested. LSC 21.3.4.1 requires ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection system components. LSC 9.6.1.4 refers to NFPA 72, The National Fire Alarm Code. NFPA 72, at 7-3.2 requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(f) and (h) requires photoelectric smoke detectors, combined heat/smoke detectors, combined audible/visual devices, separate visual devices, door magnets, and manual pull station fire alarm boxes to be functional tested annually. This deficient practice affects all patients in the facility.</p> <p>Findings include:</p> <p>Based on record review on 07/30/15 at 2:10 p.m. with the administrator, there was no annual fire alarm system inspection records to review to indicate all fire alarm system devices and components had been annually functional tested for the past year. Based on an interview with the administrator on 07/30/15 at 2:15 p.m., the facility is not contracted to have an annual fire alarm system inspection conducted. This was verified by the administrator at the time of record review and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.</p> <p>2. Based on record review and interview, the facility failed to ensure 20 of 20 smoke detectors</p>	K 051			

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K 051	Continued From page 4 were tested for sensitivity every two years in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 requires ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection system components. LSC 9.6.1.4 refers to NFPA 72, The National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.	K 051			

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K 051	Continued From page 5 The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. This deficient practice affects all patients, staff and all visitors in the facility. Findings include: Based on record review on 07/30/15 at 2:10 p.m. with the administrator, there was no records available for review to indicate the twenty photoelectric smoke detectors throughout the facility had been tested for sensitivity over the past two years. Based on an interview with the administrator on 07/30/15 at 2:15 p.m., the facility is not contracted to have smoke detector sensitivity tested every two years. This was verified by the administrator at the time of record review and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.	K 051			
K 113	416.44(b)(1) LIFE SAFETY CODE STANDARD Designated aisles, corridors, passageways, and exitways are provided with illumination in accordance with section 7.8. 20.2.8, 21.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 4 exit discharge paths were provided with double lighting fixtures on	K 113			

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K 113	Continued From page 6 emergency powered illumination. LSC 20.2.8 requires means of egress shall be illuminated in accordance with Section 7.8. LSC 7.8.1.4 requires illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice could affect all patients in the facility. Findings include: Based on observations with the business manager on 07/30/15 during a tour of the facility from 12:10 p.m. to 2:15 p.m., the light fixtures located on the exterior of the building outside of the patient exit and the delivery exit were provided with single light fixtures on the emergency power breaker panel. Based on an interview with the business manager on 07/30/15 at 12:55 p.m., the hours of operation are from 7:00 a.m. to 6:00 p.m. and staff usually come into the facility a half hour before and stay a half hour after closing hours, which would leave the exterior of the patient exit and delivery exit in darkness at the start and end of the daily shift. The lack of double light fixtures outside the patient exit and delivery exit was verified by the business manager at the time of observations and acknowledged by the administrator at the exit conference on 07/30/15 at 2:25 p.m.	K 113			
K 130	MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the	K 130			

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K 130	<p>Continued From page 7</p> <p>facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 4 of the past 4 quarters. LSC 20.7.6 requires maintenance and testing to refer to 4.6.12. LSC 4.6.12 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.5 refers to NFPA 25, the Standard for Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices including but not limited to, mechanical water motor gongs, vane-type waterflow devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all patients, staff and visitor.</p> <p>Findings include:</p> <p>Based on record review on 07/30/15 at 2:10 p.m. with the administrator, there was no record of quarterly sprinkler system inspections conducted over the past year. Based on an interview with the administrator on 07/30/15 at 2:15 p.m., the facility is not contracted to have quarterly sprinkler system inspections conducted. This was verified by the administrator at the time of record review and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.</p> <p>2. Based on interview, the facility failed to provide a written policy for the protection of 4 of 4 patients in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1. LSC 4.5.7 requires whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such</p>	K 130			

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K 130	Continued From page 8 device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review of the facility Fire Policy and interview with the administrator on 07/30/15 at 2:10 p.m., the facility did not have a written policy and procedure for an impaired automatic sprinkler system. This was verified by the administrator at the time of interview and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.	K 130			
K 144	416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110 This STANDARD is not met as evidenced by: 1. Based on record review, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 46 of 52 weeks over the past year. Chapter 3-4.4.1.3 of NFPA 99 requires storage	K 144			

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K 144	<p>Continued From page 9</p> <p>batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires storage batteries, including electrolyte levels, be inspected at intervals of not more than 7 days and shall be maintained in full compliance with the manufacturer's specifications. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the emergency generator Monthly Test log with the administrator on 07/30/15 at 2:05 p.m., weekly inspections of the emergency generator were documented for the following weeks over the past year; 06/19/15, 06/23/15, 07/06/15, 07/15/15, and 07/23/15. Based on an interview with the administrator on 07/30/15 at 2:10 p.m., weekly emergency generator inspections were not conducted before June 2015 over the past year. The lack of weekly inspections for the emergency generator before June 2015 was verified by the administrator at the time of record review and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.</p> <p>2. Based on record review and interview, the facility failed to ensure the load testing for the emergency generator was conducted for 10 of the</p>			K 144			

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K 144	<p>Continued From page 10</p> <p>past 12 months under operating conditions or not less than 30 percent of the nameplate rating for the emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the emergency generator Monthly Test log with the administrator on 07/30/15 at 2:05 p.m., monthly load tests of the emergency generator were documented for the following months over the past year; 06/30/15 and 07/26/15. Based on an interview with the administrator on 07/30/15 at 2:10 p.m., monthly load tests of the emergency generator were not conducted before June 2015 over the past year. The lack of monthly load tests for the emergency generator before June 2015 was verified by the administrator at the time of record review and acknowledged at the exit conference on 07/30/15 at 2:25 p.m.</p>	K 144			